Your Medicare Rights and Protections

This official government booklet has important information about:

- Your right to file a complaint.
- Your right to get health care services you need.
- Where you can get help with your questions.

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Note: At the time of printing, telephone numbers listed were correct. Telephone numbers sometimes change. To get the most up-to-date telephone numbers, look at www.medicare.gov on the web. Select "Helpful Contacts." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date version, look at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). A Customer Service Representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

Your Medicare Rights and Protections booklet isn't a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

How This Booklet Can Help You

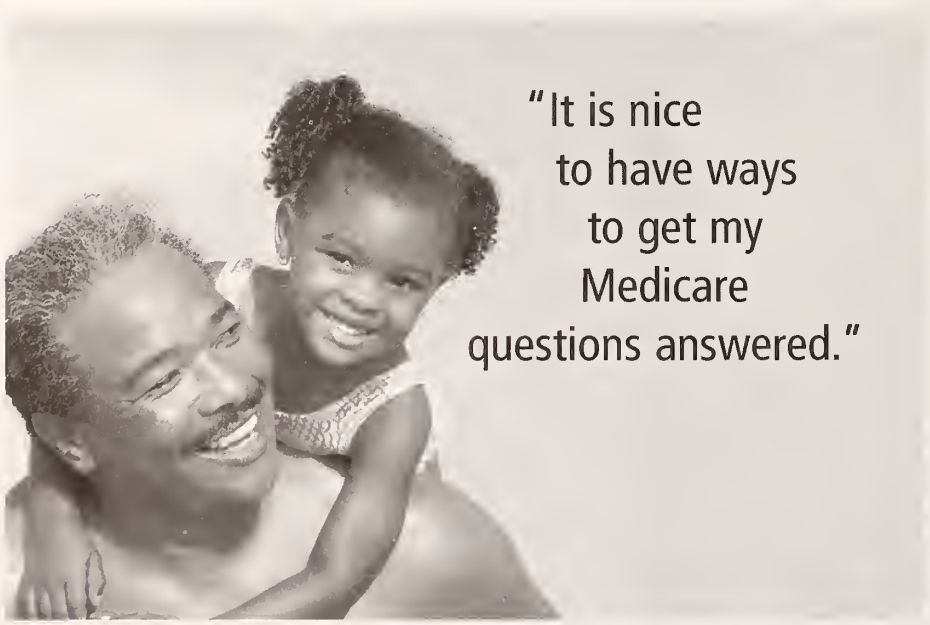
This booklet is about your Medicare rights and protections. As a person with Medicare, you have certain guaranteed rights and protections that

- protect you when you get health care,
- make sure you get the health care services that the law says you can get, and
- protect you against unethical practices.

Remember, you have rights no matter if you are in the Original Medicare Plan, a Medicare + Choice Plan (pronounced "Medicare plus Choice"), or have a Medigap (Medicare Supplement Insurance) policy.

This booklet provides you with valuable information and helps you understand

- your Medicare health plan choices,
- your rights and protections in the Original Medicare Plan,
- your rights and protections in a Medicare + Choice Plan, and
- where to get help with your questions.



Words in brown are defined on pages 31–33.

Section 1: A Quick Look At Medicare

What is Medicare?

Medicare is a health insurance program for

- people age 65 or older,
- some people under age 65 with certain disabilities, and
- people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney tranplant).

What are my Medicare health plan choices?

Depending on where you live, you may be able to get your health care in several ways. Your Medicare health plan choices include

- the Original Medicare Plan (see below), or
- Medicare + Choice Plans (see page 4).

What is the Original Medicare Plan?

The Original Medicare Plan is a "fee-or-service" plan. You are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice Plan. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care.

To help cover the costs the Original Medicare Plan doesn't cover, you may want to get a Medigap policy (see page 4).

Words in brown are defined on pages 31–33.

What is a Medigap policy?

A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage such as coinsurance amounts.

Medigap policies must follow federal and state laws. These laws protect you. There are ten standardized Medigap plans called "A" through "J." The front of a Medigap policy must clearly identify it as "Medicare Supplement Insurance." Each plan A through J has a different set of benefits.

For more information about Medigap policies, get a free copy of the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110) by looking at www.medicare.gov on the web. Select "Publications." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What are Medicare + Choice Plans?

Congress created the Medicare + Choice program to provide you with more choices and, sometimes, extra benefits by letting private companies offer you your Medicare benefits. If you join a Medicare + Choice Plan, you may have the following choices:

- Medicare Managed Care Plans
- Medicare Private Fee-for-Service Plans
- Medicare Preferred Provider Organization Plans
- Medicare Specialty Plans

These Medicare + Choice Plans are available in many areas of the country. A company can decide, with Medicare's approval, that a plan will be available to everyone with Medicare in a state, or be open only in certain counties or parts of counties. A company may also choose to offer more than one plan in an area, with different benefits and costs.

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice Plan manages the Medicare coverage for its members. If Medicare + Choice Plans are available in your area, and you have Medicare Part A and Part B, you can join one and get your Medicare-covered benefits through the plan. The plan may have special rules you need to follow. You may also have to pay a monthly premium for extra benefits.

Section 2: Your Medicare Rights

If you have Medicare, you have certain guaranteed rights and protections. You have these rights whether you have the Original Medicare Plan, a Medigap policy, or a Medicare + Choice Plan. You have the right to:

1. Be treated with dignity and respect at all times

2. Be protected from discrimination

Discrimination is against the law. Every company or agency that works with Medicare must follow Civil Rights laws. They can't discriminate against you because of your

- race,
- color,
- national origin,
- disability,
- age, or
- religion (under certain conditions).

If you think you have been discriminated against for any of these reasons, call the Office for Civil Rights in your state. You can get this number from two sources:

- www.medicare.gov on the web. Select "Helpful Contacts."
- 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048.

You can have someone help you overcome a language, physical, or communication barrier if you need it.

3. Get information about Medicare that you can understand to help you make health care decisions

This information includes

- what is covered,
- what costs are paid,
- how much you have to pay, and
- what to do if you want to file a complaint.

You can have someone help you make decisions when you need it.

Words in brown are defined on pages 31–33.

4. Have your questions about the Medicare program answered

To get your questions answered, you can call

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can get help in English or Spanish, or
- your State Health Insurance Assistance Program (see page 30).

5. Get emergency care when and where you need it

A medical emergency is when you think your health is in serious danger—when every second counts. If you think your health is in danger because you have a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

If you are in Medicare + Choice Plan, you don't need to get permission from your primary care doctor before you get emergency care. Your primary care doctor is the doctor you see first for health problems. If you get emergency care, you will have to pay your regular share of the cost (copayment). Then, your plan will pay its share. If your plan doesn't pay its share for your emergency care, you have the right to appeal (see page 7).

6. Learn about all of your treatment choices in clear language that you can understand

You have the right to fully participate in all your health care decisions. If you can't fully participate, you can ask family members, friends, or anyone you trust to help you make a decision about what treatment is right for you. Medicare health plans can't have rules that stop your doctor from telling you what you need to know about your treatment choices.

Words in brown are defined on pages 31–33.

7. File a complaint

You can file a complaint about payment, services you received, other concerns or problems you have in getting health care, and the quality of the health care you received.

Your Medicare Appeals Rights

You have the right to appeal any official decision about your Medicare services, such as billing, payment, or service issues. You can appeal if Medicare doesn't

- pay for a Medicare-covered item or service you have been given,
- pay enough for an item or service you have been given, or
- give you a Medicare-covered item or service you think you should get.

For more information on filing an appeal, call your State Health Insurance Assistance Program (see page 30).

Your Medicare Quality of Care Concerns

You have a right to file a complaint if you think you aren't getting quality services or you have quality of care issues. This type of complaint is called a "grievance" if you are enrolled in a Medicare + Choice Plan. If you want to file a complaint about the quality of health care you have received, call the Quality Improvement Organization (QIO) in your state (see page 28). If you are enrolled in a Medicare + Choice Plan, you may also call your plan.

You can also file a complaint if you think your privacy rights have been violated. If you are in the Original Medicare Plan, see the Notice of Privacy Practices for the Original Medicare Plan on pages 18–20 for more information. If you are enrolled in a Medicare + Choice Plan, call your health plan directly for more information.

Words in brown are defined on pages 31–33.

8. Have your personal information that Medicare collects about you kept private

Medicare may collect information about you as part of its regular business, such as paying your health care bills and making sure you get quality health care. Medicare keeps the information it collects about you private. When Medicare asks for your personal information, they must tell you the following:

- Why it is needed
- Whether it is required or optional
- What happens if you don't give the information
- How it will be used

If you want to know more about how Medicare uses your personal information, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your state may have additional privacy laws that protect your personal information. If you want to know about the laws in your state, call your State Health Insurance Assistance Program (see page 30).

9. Talk with your health care providers in private and have your personal health care information kept private

There is a new patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used by your health care provider or health plan. Health plans and covered health care providers must give you a notice that clearly explains these rights and practices. If you are enrolled in the Original Medicare Plan, see the Notice of Privacy Practices on pages 18–20. If you are enrolled in a Medicare + Choice Plan, your plan materials describe your privacy rights.

Words in brown are defined on pages 31–33.

Section 3: Your Rights and Protections in the Original Medicare Plan

In addition to the rights listed in Section 2, if you are in the Original Medicare Plan, you have the following rights and protections:

1. Culturally Competent Services

You have the right to get health care services in a language you can understand and in a culturally sensitive way. For more information about getting health care services in languages other than English, call the Office for Civil Rights in your state. You can get this telephone from two sources:

- www.medicare.gov on the web. Select "Helpful Contacts."
- 1-800-MEDICARE (1-800-633-4227).
  TTY users should call 1-877-486-2048.

2. Access to Doctors, Specialists (including Women's Health Specialists), and Hospitals

You can go to any doctor, specialist, or hospital that accepts Medicare.

3. A Fair, Efficient, and Timely Appeals Process

The appeals process can help you resolve issues about payment for a Medicare-covered service or item. This process includes a system of internal review and an independent external review.

If you need to file an appeal, look on the back of the Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will tell you why your bill wasn't paid, how long you have to file an appeal, and what appeal steps you can take. If you decide to file an appeal, ask your doctor or provider for any information that might help your case. You should keep a copy of everything you send to Medicare as part of your appeal.

Words in brown are defined on pages 31–33.

3. A Fair, Efficient, and Timely Appeals Process (continued)

You will have the right to a new expedited appeals process beginning January 1, 2004. This option will be available whenever you believe that your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. If you are receiving services from a home health agency or comprehensive outpatient rehabilitation facility, you will need the doctor who is treating you to certify that you still need care. You will be able to get a decision within 72 hours from independent doctors who will look at your case and decide if your services need to continue.

4. Know If Medicare Won't Pay for a Service You are Getting

You have the right to know if Medicare probably (or certainly) won't pay for items or services that are usually covered.

Your doctor, provider, or supplier should give you a written notice before they give you any item or service that they think Medicare may not pay for. This written notice is called an Advance Beneficiary Notice (ABN). The ABN explains what items and services Medicare won't pay for and why Medicare won't pay for it. The ABN gives you the chance to make an informed decision about whether you want to get the item or service when you may have to pay for it yourself or through other insurance you might have.

Words in brown are defined on pages 31–33.

Section 3: Your Rights and Protections in the Original Medicare Plan

4. Know If Medicare Won't Pay for a Service You are Getting (continued)

What to do if you get an ABN

If your doctor, provider, or supplier gives you an ABN, you will have to decide if you want the item or service. You will be asked to choose between Option 1 or Option 2 by marking a box and signing the ABN. If you choose

- Option 1, this means you want the item or service and agree to pay for it out of your own pocket or through other health insurance you may have, if Medicare doesn't pay.
- Option 2, this means you don't want the item or service.

You can only get an official Medicare decision if you choose Option 1.

What to do if you aren't sure Medicare received a bill

If you aren't sure if Medicare was billed for the items or services that you got, write or call your health care provider and ask for an itemized statement. This statement will list each Medicare item or service you got from your doctor, hospital, or any other health supplier. You should get your copy of the itemized statement within 30 days. Also, you can check your Medicare Summary Notice to see if Medicare was billed for the service.

Services that Medicare doesn't cover

Doctors and suppliers of health care services don't have to give you an ABN for services that Medicare doesn't cover, such as

- routine physical exams,
- dental services,
- hearing aids,
- routine eye exams, and
- routine foot care.

Words in brown are defined on pages 31–33.

5. Hospital Care

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you aren't given a copy, ask for it.

The *Important Message From Medicare* notice tells you

- you have the right to get all of the hospital care you need, and any follow-up care that is covered by the Original Medicare Plan after you leave the hospital,
- what to do if you think the hospital is making you leave too soon,
- what your appeal rights are, and
- what you may have to pay.

When the hospital staff thinks you no longer need inpatient hospital care, they will give you a notice about your discharge and appeal rights if you think you still need hospital care. If you aren't given a notice, ask for it.

This notice explains

- why you are being discharged,
- how to get an immediate review,
- when to ask for an immediate review, and
- what you may have to pay.

Words in brown are defined on pages 31–33.

5. Hospital Care (continued)

When you get this notice, if you think the hospital is making you leave too soon, you can ask for an immediate review by the Quality Improvement Organization (QIO). To get an immediate review, you can call or write the QIO (see page 28). **You may be able to stay in the hospital at no charge while the QIO reviews your case. The hospital can't force you to leave before the QIO makes a decision.**

Important: Before you are discharged from the hospital, the hospital must give you a notice about your discharge and appeal rights if you think your hospital care should continue. If the hospital doesn't notify you of your discharge and appeal rights, and you decide to stay in the hospital after your discharge date, you can't be charged for the costs of your care.

If you have questions about your rights as a hospital patient, call the QIO in your state (see page 28). Their telephone number is also on the notice of discharge and appeal rights the hospital gives you.

6. Skilled Nursing Facility Care

A skilled nursing facility (SNF) is a Medicare-certified facility that has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services.
You must meet certain conditions, such as a 3-day hospital stay, for skilled nursing facility care coverage before you are admitted. Some nursing homes give this type of skilled care.

If you are in a SNF, you are protected when your coverage ends. The SNF staff gives you a *Notice of Non-Coverage* when they think you no longer qualify for Medicare coverage. If you think that you still need skilled nursing facility care, you have the right to have Medicare review the SNF's opinion to decide if you still qualify for Medicare coverage.

Words in brown are defined on pages 31–33.

6. Skilled Nursing Facility Care (continued)

To have Medicare decide if you still qualify for SNF coverage:

1. The SNF must send a special kind of claim to Medicare. This claim is sometimes called a "demand bill." Check off the box on the *Notice of Non-Coverage* to show that you want a demand bill sent to Medicare.
2. Give the notice to the SNF.
3. The SNF sends the demand bill to Medicare.
4. Medicare decides if you still qualify for Medicare-covered SNF care.
5. The SNF will let you know Medicare's decision.

The SNF must submit the demand bill. You don't have to pay a deposit for services that Medicare may not cover until Medicare makes its decision. You must continue to pay any costs that you would normally have to pay while the demand bill is being processed. This includes the daily coinsurance and the costs for services and supplies Medicare doesn't cover.

If Medicare decides your care is no longer covered, you are responsible for the cost of the care you got while you were waiting for the decision.

You can file an appeal if you don't agree with Medicare's decision. To find out how to appeal in the Original Medicare Plan, read the back of the Medicare Summary Notice (MSN) or Notice of Utilization you get from the company that handles bills for Medicare.

Words in brown are defined on pages 31–33.

7. Home Health Care

If you are getting home health care services, you are protected when your home health care is reduced or ends. Home health care agencies must give you a written Home Health Advance Beneficiary Notice (HHABN) that explains why and when they think Medicare will stop paying for all or part of your home health care ordered by your doctor. Also, home health care agencies must give you a written notice before you get home health care if they think Medicare won't pay for some or all of the home health care services your doctor ordered.

What to do if you get an HHABN

If your home health agency gives you an HHABN, you will have to decide if you want the services or not. You will be asked to choose between Option A, Option B, or Option C. If you choose

- Option A, this means you want the services and agree to pay for them out of your own pocket or through other health insurance you may have, if Medicare doesn't pay.
- Option B
  - First box, this means you want the services, but don't want the home health agency to send a claim to Medicare. The home health agency may send the claim to Medicaid or the other insurance you may have.

    Note: If you have Medicaid, and Medicaid is acting on your behalf, Medicaid may tell the home health agency to send the claim to Medicare. In this case, the home health agency will send the claim to Medicare.
  - Second box, this means you want the services, but don't want the home health agency to send a claim to Medicare, Medicaid, or any other insurance you may have. The home health agency will send the claim to you for payment.
- Option C, this means you don't want the services.

You can only get an official Medicare decision if you choose Option A.

Words in brown are defined on pages 31–33.

7. Home Health Care (continued)

If you choose Option A and want an official decision, you should

- keep getting home health care if you think you need it. Ask how much it will cost. You should talk to your doctor and family about this decision.
- pay the home health agency for those services.
- ask the home health agency to send your claim to Medicare so that Medicare can decide if it will pay. If Medicare doesn't decide in your favor, you can appeal (see page 7).

If Medicare decides to pay, you will get back any of your payments that you are due. If Medicare decides **not** to pay, you will get a letter that tells you how to appeal. You can always get home health care if you want to pay for it yourself. If you have questions about home health care in the Original Medicare Plan, call the Regional Home Health Intermediary in your state (see page 29).

8. Your Rights to Buy A Medigap Policy

In some situations, you have the right to buy a Medigap policy outside of your Medigap open enrollment period. These rights are called "Medigap Protections." They are also called guaranteed issue rights because the law says that insurance companies must issue you a Medigap policy.

There are a few situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy. In these situations, an insurance company

- can't deny you Medigap coverage or place conditions on a policy (like making you wait for coverage to start),
- must cover you for all pre-existing conditions, and
- can't charge you more for a policy because of past or present health problems.

Words in brown are defined on pages 31–33.

8. Your Rights to Buy A Medigap Policy (continued)

To learn about the situations where you have a guaranteed issue right to buy a Medigap policy because you lost certain kinds of health coverage, you can

- look at www.medicare.gov on the web. Select "Publications" and choose the booklet the *Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110).
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Ask for a free copy of this Guide.

For more detailed Medigap information

- look at www.medicare.gov on the web. Select "Medicare Personal Plan Finder."
- call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. A Customer Service Representative will help you. You will get your "Medicare Personal Plan Finder" results in the mail within three weeks.
- call your State Health Insurance Assistance Program (see page 30). Ask if they have a Medigap rate comparison shopping guide for your state.

If you think any of your Medigap rights have been violated, call your State Health Insurance Assistance Program.

Words in brown are defined on pages 31–33.

Section 3: Your Rights and Protections in the Original Medicare Plan

Notice of Privacy Practices for the Original Medicare Plan

The Notice of Privacy Practices for the Original Medicare Plan describes how Medicare uses and gives out your personal health information and tells you your individual rights. The notice is below, and on pages 19 and 20.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, Medicare is required to protect the privacy of your personal medical information. Medicare is also required to give you this notice to tell you how Medicare may use and give out ("disclose") your personal medical information held by Medicare.

Medicare **must** use and give out your personal medical information to provide information

- to you or someone who has the legal right to act for you (your personal representative),
- to the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected, and
- where required by law.

Medicare **has the right** to use and give out your personal medical information to pay for your health care and to operate the Medicare program. For example

- Medicare Carriers use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), or to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other Medicare beneficiaries get quality health care, to provide customer services to you, to resolve any complaints you have, or to contact you about research studies.

Notice of Privacy Practices for the Original Medicare Plan (continued)

Medicare **may** use or give out your personal medical information for the following purposes under limited circumstances:

- To state and other federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government healthcare oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing limited information to locate a missing person)
- For research studies that meet all privacy law requirements (such as research related to the prevention of disease or disability)
- To avoid a serious and imminent threat to health or safety

  To contact you about new or changed benefits under Medicare
- To create a collection of information that can no longer be traced back to you

By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

By law, you have the right to

- see and get a copy of your personal medical information held by Medicare.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and Medicare agrees. If Medicare disagrees, you may have a statement of your disagreement added to your personal medical information.

Notice of Privacy Practices for the Original Medicare Plan (continued)

- get a listing of those getting your personal medical information from Medicare. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your healthcare or for Medicare operations, or that was given out for law enforcement purposes.
- ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare program. Please note that Medicare may not be able to agree to your request.
- get a separate paper copy of this notice.

Look at www.medicare.gov on the web for more information on

- exercising your rights set out in this notice, and
- filing a complaint, if you believe the Original Medicare Plan has violated these privacy rights. Filing a complaint won't affect your benefits under Medicare.

You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. Ask to speak to a Customer Service Representative about Medicare's privacy notice. TTY users should call 1-877-486-2048.

To file a complaint with the Secretary of the Department of Health and Human Services, visit www.hhs.gov/ocr/hippa or contact the Office for Civil Rights at 1-866-627-7748. TTY users should call 1-800-537-7697.

By law, Medicare is required to follow the terms in this privacy notice. Medicare has the right to change the way your personal medical information is used and given out. If Medicare makes any changes to the way your personal medical information is used and given out, you will get a new notice by mail within 60 days of the change.

The privacy practices listed above and on pages 18 and 19 became effective April 14, 2003.

Section 4: Your Rights and Protections in a Medicare Managed Care Plan

In addition to the rights listed in Section 2, if you are in a Medicare Managed Care Plan, you have the following rights and protections:

1. Culturally Competent Services

You have the right to get health care services in a language you can understand and in a culturally sensitive way.

2. Choice of Health Care Providers

You have the right to choose health care providers within the plan so you can get the health care you need.

3. Access to Health Care Providers

If you have a complex or serious medical condition, you have the right to get a treatment plan from your doctor. This treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need.

Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.

4. Know How Your Doctors Are Paid

You have the right to know how your health plan pays its doctors. When you ask your health plan how it pays its doctors, the health plan must tell you. Medicare doesn't allow a health plan to pay doctors in a way that wouldn't let you get the care you need.

5. A Fair, Efficient, and Timely Appeals Process

The appeals process helps you resolve differences with your health plan. This process includes a system of internal review and an independent external review.

You have the right to file an appeal if your plan won't pay for, doesn't allow, or stops a service you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours if

- it determines your life or health could be seriously harmed if the plan took the normal 30 days to respond, or
- a doctor supports your request and certifies you would be harmed.

Words in brown are defined on pages 31–33.

5. A Fair, Efficient, and Timely Appeals Process (continued)

You also have the right to ask your plan for a copy of the file that contains your medical and other information about your appeal. You may want to call or write your plan and ask for a copy of your file. The plan may charge you a fee for copying this information and sending it to you.

The plan must tell you, in writing, why they won't pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan doesn't decide in your favor, your appeal is automatically sent to an independent organization that works for Medicare, not for the plan. This independent organization will review your appeal. You have a right to get a copy of the case file that the plan sends to the independent organization, if you ask for it.

If you are enrolled in a Medicare + Choice Plan, you will have the right to a new fast track appeals process beginning January 1, 2004. This option will be available whenever you are receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility. You will receive a notice from your provider that will tell you how to ask for an appeal if you think your health plan is ending these services too soon. You will be able to get a quick review of this decision, with independent doctors looking at your case and deciding if your services need to continue.

See your plan's membership materials or call your plan for details about your appeal rights.

6. File A Grievance About Other Concerns or Problems

You have a right to file a grievance if you have concerns or problems with your Medicare Managed Care Plan that aren't about payment or service requests. For example, if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

Words in brown are defined on pages 31–33.

7. Hospital Care

If you are admitted to a hospital that takes Medicare patients, you should be given a copy of the *Important Message From Medicare* notice. It explains your rights as a hospital patient. If you aren't given a copy, ask for it.

The *Important Message From Medicare* notice tells you

- you have the right to get all of the hospital care you need, and any follow-up care that is covered by your Medicare Managed Care Plan after you leave the hospital,
- what to do if you think the hospital is making you leave too soon,
- what your appeal rights are, and
- what you may have to pay.

When the hospital staff thinks you no longer need inpatient hospital care, they will give you a notice about your discharge and appeal rights if you think your hospital care should continue. If you aren't given a notice, ask for it. This notice explains

- why you are being discharged,
- how to get an immediate review,
- when to ask for an immediate review, and
- what you may have to pay.

When you get this notice, if you think the hospital is making you leave too soon, you can ask for an immediate review by the Quality Improvement Organization (QIO). To get an immediate review, you can call or write the QIO (see page 28). **You may be able to stay in the hospital at no charge while the QIO reviews your case. The hospital can't force you to leave before the QIO makes a decision.**

Words in brown are defined on pages 31–33.

7. Hospital Care (continued)

Important: Before you are discharged from the hospital, the hospital must give you a notice about your discharge and appeal rights if you think your hospital care should continue. If the hospital doesn't notify you of your discharge and appeal rights, and you decide to stay in the hospital after your discharge date, you can't be charged for the costs of your care.

If you have questions about your rights as a hospital patient, call your Medicare Managed Care Plan or the QIO in your state (see page 28). Their telephone numbers are on the notice of discharge and appeal rights the hospital gives you.

8. Skilled Nursing Facility Care

If you are in a skilled nursing facility, the plan must tell you, in writing, why you don't need skilled care any longer if you think it continues to be medically necessary. If you want to appeal this decision, the plan's *Notice of Non-Coverage* will tell you the steps you need to take. The plan may have to continue to pay the costs of your care if you don't get proper notice. Call your plan for more information about skilled nursing facility coverage.

9. Home Health Care

If you have questions about home health care rights and protections, call your plan.

Special Note about Medicare Preferred Provider Organization Plans and Medicare Specialty Plans:

If you are in a Medicare Preferred Provider Organization Plan or Medicare Specialty Plan, you have many of the same rights as people in Medicare Managed Care Plans. If you are in one of these plans and want to know your rights, read your plan's membership materials or call your plan.

Section 5: Your Rights and Protections in a Medicare Private Fee-for-Service Plan

In addition to the rights listed in Section 2, if you are in a Medicare Private Fee-for-Service Plan, you have the following rights and protections:

1. Culturally Competent Services

You have the right to get health care services in a language you can understand and in a culturally sensitive way.

2. A Fair, Efficient, And Timely Appeals Process

You have the right to a fair, efficient, and timely process to resolve differences with your health plan. This process includes a system of internal review and an independent external review.

You have the right to file an appeal if your plan won't pay for, doesn't allow, or stops a service you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours if

- it determines your life or health could be seriously harmed if the plan took the normal 30 days to respond, or
- a doctor supports your request and certifies you would be harmed.

You also have the right to ask your plan for a copy of the file that contains your medical and other information about your appeal. You may want to call or write your plan and ask for a copy of your file. The plan may charge you a fee for copying this information and sending it to you.

The plan must tell you, in writing, why they won't pay for or allow you to get a service, and how to appeal this decision. After you file your appeal, the plan will review its decision. Then, if the plan doesn't decide in your favor, your appeal is automatically sent to an independent organization that works for Medicare, not for the plan. This independent organization will review your appeal. You have a right to get a copy of the case file that the plan sends to the independent organization, if you ask for it.

Words in brown are defined on pages 31–33.

2. A Fair, Efficient, And Timely Appeals Process (continued)

You will have the right to a new fast track appeals process beginning January 1, 2004. This option will be available whenever you are receiving services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

You will receive a notice from your provider that will tell you how to ask for an appeal if you think your health plan is ending these services too soon. You will be able to get a quick review of this decision, with independent doctors looking at your case and deciding if your services need to continue.

See your plan's membership materials or call your plan for details about your appeals rights.

3. File A Grievance About Other Concerns or Problems

You have a right to file a grievance if you have concerns or problems with your Medicare Private Fee-for-Service Plan that aren't about payment or service requests. For example, if you believe your plan's hours of operation should be different, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

4. Call your Medicare Private Fee-for-Service Plan

- before you get a service or supply to find out if it will be covered. Your plan must tell you if you ask.
- to find out your protections when you are in the hospital.
- to get information about skilled nursing facility coverage.
- if you have questions about home health care rights and protections.

Words in brown are defined on pages 31–33.

Section 6: For More Information

Booklets on Other Medicare Topics

Health care decisions are important. Medicare tries to give you information to help you make good decisions. You can order free booklets from Medicare to learn more about the topics that are of interest to you. We are always adding new booklets with detailed information about important subjects.

How do I get these booklets?

To get these booklets, you can do the following:

1. Look at www.medicare.gov on the web and select "Publications." You can read, print, or order these booklets. This is the fastest way to get a copy.
2. Call 1-800-MEDICARE (1-800-633-4227). Just say "Publications." TTY users should call 1-877-486-2048. You will get your copy within three weeks.
3. Put your name on the web mailing list to get an e-mail message every time a new booklet is available. To sign up, go to www.medicare.gov and select "Mailing List" at the bottom of the page. Then select the topic "Publications" and choose "Join or leave the list, or update options."

Many booklets are available in English, Spanish, Audiotape (English and Spanish), Braille, and Large Print (English and Spanish). Look at www.medicare.gov on the web for a list of available publications.

Note: Some booklets may not be available in print, but all of the most up-to-date versions will be available at www.medicare.gov on the web. If you don't have a computer, your local library may be able to help you.

Section 6: For More Information

Quality Improvement Organization (QIO): Call about quality of care concerns, filing an appeal or complaint, or for questions about your rights as a hospital patient.

Alabama	(800) 760-3540
Alaska	(800) 445-6941
American Samoa	(800) 524-6550
Arizona	(800) 359-9909
Arkansas	(800) 272-5528
California	(800) 841-1602
Colorado	(800) 727-7086
Connecticut	(800) 553-7590
Delaware	(866) 475-9669
Florida	(800) 844-0795
Georgia	(800) 979-7217
Guam	(800) 524-6550
Hawaii	(800) 524-6550
Idaho	(800) 445-6941
Illinois	(800) 647-8089
Indiana	(800) 288-1499
Iowa	(800) 752-7014
Kansas	(800) 432-0407
Kentucky	(800) 288-1499
Louisiana	(800) 433-4958
Maine	(800) 772-0151
Maryland	(800) 492-5811
Massachusetts	(781) 890-0011
Michigan	(800) 365-5899
Minnesota	(800) 444-3423
Mississippi	(800) 844-0600
Missouri	(800) 347-1016
Montana	(800) 497-8232
Nebraska	(800) 247-3004
Nevada	(800) 748-6773
New Hampshire	(800) 772-0151
New Jersey	(732) 238-5570
New Mexico	(800) 279-6824
New York	(800) 331-7767
North Carolina	(800) 722-0468
North Dakota	(701) 852-4231
Northern Mariana Islands	(800) 524-6550
Ohio	(800) 589-7337
Oklahoma	(800) 522-3414
Oregon	(800) 344-4354
Pennsylvania	(800) 322-1914
Puerto Rico	(787) 641-1240
Rhode Island	(800) 662-5028
South Carolina	(803) 731-8225
South Dakota	(800) 658-2285
Tennessee	(800) 528-2655
Texas	(800) 725-8315
Utah	(800) 274-2290
Vermont	(800) 772-0151
Virgin Islands	(340) 712-2444
Virginia	(804) 289-5304
Washington	(800) 445-6941
Washington D.C.	(800) 645-0011
West Virginia	(800) 642-8686 x2266
Wisconsin	(800) 362-2320
Wyoming	(800) 497-8232

Section 6: For More Information

Regional Home Health Intermediary: Call about questions on home health care, hospice care, and fraud and abuse.

Alabama .....(800) 583-2236
Alaska .....(866) 804-0684
American Samoa .....(866) 264-4990
Arizona .....(866) 804-0684
Arkansas .....(800) 583-2236
California .....(866) 804-0684
Colorado .....(877) 910-8139
Connecticut .....(888) 896-4997
Delaware .....(877) 910-8139
Florida.....(800) 583-2236
Georgia .....(800) 583-2236
Guam .....(866) 264-4990
Hawaii.....(866) 264-4990
Idaho.....(866) 804-0684
Illinois.....(800) 583-2236
Indiana .....(800) 583-2236
Iowa .....(877) 910-8139
Kansas.....(877) 910-8139
Kentucky.....(800) 583-2236
Louisiana.....(800) 583-2236
Maine .....(888) 896-4997
Maryland.....(877) 910-8139
Massachusetts .....(888) 896-4997
Michigan.....(800) 531-9695
Minnesota .....(800) 531-9695
Mississippi.....(800) 583-2236
Missouri .....(877) 910-8139
Montana .....(877) 910-8139
Nebraska .....(877) 910-8139
Nevada .....(866) 804-0684
New Hampshire .....(888) 896-4997
New Jersey .....(800) 531-9695
New Mexico .....(800) 583-2236
New York .....(800) 531-9695
North Carolina .....(800) 583-2236
North Dakota .....(877) 910-8139
Northern Mariana Islands.....(866) 264-4990
Ohio .....(800) 583-2236
Oklahoma .....(800) 583-2236
Oregon .....(866) 804-0684
Pennsylvania .....(877) 910-8139
Puerto Rico .....(800) 531-9695
Rhode Island .....(888) 896-4997
South Carolina .....(800) 583-2236
South Dakota .....(877) 910-8139
Tennessee .....(800) 583-2236
Texas .....(800) 583-2236
Utah .....(877) 910-8139
Vermont .....(888) 896-4997
Virgin Islands .....(800) 531-9695
Virginia .....(877) 910-8139
Washington .....(866) 804-0684
Washington D.C. .....(877) 910-8139
West Virginia .....(877) 910-8139
Wisconsin .....(800) 531-9695
Wyoming .....(877) 910-8139

Section 6: For More Information

State Health Insurance Assistance Program: Call for help with buying a Medigap policy or long-term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, help choosing a Medicare health plan, or Medicare bills.

Alabama .....(800) 243-5463
Alaska .....(907) 269-3680
American Samoa .....(888) 875-9229
Arizona .....(800) 432-4040
Arkansas .....(800) 224-6330
California .....(800) 434-0222
Colorado .....(888) 696-7213
Connecticut .....(860) 424-5245
Delaware .....(302) 739-6266
Florida.....(800) 963-5337
Georgia .....(800) 669-8387
Guam .....(888) 875-9229
Hawaii.....(888) 875-9229
Idaho.....(208) 334-4350
Illinois.....(217) 785-9021
Indiana .....(317) 232-5299
Iowa .....(800) 351-4664
Kansas.....(316) 337-7386
Kentucky.....(877) 293-7447
Louisiana.....(225) 342-5301
Maine .....(207) 623-1797
Maryland.....(410) 767-1100
Massachusetts .....(800) 243-4636
Michigan.....(800) 803-7174
Minnesota .....(800) 333-2433
Mississippi.....(800) 948-3090
Missouri .....(800) 390-3330
Montana .....(406) 444-4077
Nebraska .....(800) 234-7119
Nevada .....(800) 307-4444
New Hampshire .....(603) 225-9000
New Jersey .....(609) 943-3437
New Mexico .....(505) 827-7640
New York .....(800) 333-4114
North Carolina .....(919) 733-0111
North Dakota .....(800) 247-0560
Northern Mariana Islands.....(888) 875-9229
Ohio .....(800) 686-1578
Oklahoma .....(405) 521-6628
Oregon .....(503) 947-7984
Pennsylvania .....(800) 783-7067
Puerto Rico .....(877) 725-4300
Rhode Island.....(401) 462-3000
South Carolina .....(800) 868-9095
South Dakota .....(800) 536-8197
Tennessee .....(877) 801-0044
Texas .....(800) 252-9240
Utah .....(801) 538-3910
Vermont .....(802) 748-5182
Virgin Islands.....(340) 772-7368
Virginia .....(800) 552-3402
Washington .....(800) 397-4422
Washington D.C. .....(202) 739-0668
West Virginia .....(877) 987-4463
Wisconsin .....(800) 242-1060
Wyoming .....(800) 856-4398

Section 7: Words To Know

Appeal - An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services, or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Medicare + Choice Plan or the Original Medicare Plan must use when you ask for an appeal.

Coinsurance - The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20%).

Copayment - In some Medicare health plans, the amount that you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay for a service. For example, this could be $10 or $20 for a doctor's visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

End-Stage Renal Disease (ESRD)* - Kidney failure that is severe enough to need lifetime dialysis or a kidney transplant.

Grievance - A complaint about the way your Medicare health plan is giving care. For example, you may file a grievance if you have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance isn't the same as an appeal, which is the way to deal with a complaint about a treatment decision or a service that isn't covered (see Appeal).

Guaranteed Issue Rights (also called "Medigap Protections") - Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

Home Health Care - Skilled nursing care and certain other health care you get in your home for the treatment of an illness or injury.

Medicare + Choice Plan - A Medicare program that gives you more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have End-Stage-Renal Disease unless certain exceptions apply.

* This definition in whole or in part was used with permission from Walter Feldesman, Esq., "Dictionary of Eldercare Terminology 2000."

Section 7: Words To Know

Medicare Managed Care Plan - A Medicare + Choice Plan option that is available in some areas of the country. In most managed care plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extras, like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Medicare Preferred Provider Organization (PPO) Plan - A Medicare + Choice Plan in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Medicare Private Fee-for-Service Plan - A Medicare + Choice Plan option in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Medicare Specialty Plan - A Medicare + Choice Plan that provides more focused health care for some people. These plans give you all your Medicare health care as well as more focused care to manage a disease or condition such as congestive heart failure, diabetes, or End-Stage Renal Disease.

Medicare Summary Notice (MSN) - A notice you get after the doctor files a claim for Part A and Part B services in the Original Medicare Plan. It explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay. You might also get a notice called a Notice of Utilization.

Medigap Policy - A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are ten standardized plans labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Open Enrollment Period (Medigap) - A one-time only, six month period when you can buy any Medigap policy you want that is sold in your state. It starts when you sign up for Medicare Part B and you are age 65 or older. During this period, you can't be denied coverage or charged more due to past or present health problems.

Original Medicare Plan - A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Quality Improvement Organization (QIO) - Groups of practicing doctors and other health care experts paid by the Federal Government to check and improve the care given to Medicare patients. They must review complaints you have about your Medicare-covered services and questions about your rights as a hospital patient.

Regional Home Health Intermediary (RHHI) - A private company that contracts with Medicare to pay home health bills and check on the quality of home health care.

Skilled Nursing Facility (SNF) - A facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitative services and other related health services.

Skilled Nursing Facility Care - A level of care that requires daily involvement of skilled nursing or rehabilitation staff. Examples of skilled nursing facility care include intravenous injections and physical therapy. Needing custodial care, such as help with bathing and dressing, can't, in itself, qualify you for Medicare coverage in a skilled nursing facility. However, if you qualify for skilled nursing or rehabilitation care, Medicare covers all of your care needs in the facility.

State Health Insurance Assistance Program - A State program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare.


"It sure makes me feel
good to know that
Medicare protects me."

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- For additional information, call 1-800-MEDICARE (1-800-633-4227). This 24-hour Helpline is available to help you with your Medicare questions. TTY users should call 1-877-486-2048.

- ¿Necesita usted una copia en español? Llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.